

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

KATHLEEN HODSON

Plaintiff,

VS.

ALPINE MANOR, INC. d/b/a
INTEGRATED HEALTH SERVICES
OF ERIE AT BAYSIDE

Defendant.

Civil Action No. 03 - 0374e

Judge Maurice B. Cohill, Jr.

EXHIBITS TO DEFENDANT'S REPLY BRIEF
IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT



Certified 7000 1530 0005 5531 5477

February 4, 2002

Ms. Kathleen Hodson
2201 Keystone Drive
Erie, PA 16509

Ms. Hodson:

On Thursday, January 31, 2002 you presented to Sheila Rist in Human Resources, a paper signed by Chiropracter, Dr. Ang. This paper states that you will be excused from work from January 31 through February 28, 2002, when you will be re-evaluated by Dr. Ang.

We spoke with Lisa Williams of the worker's comp insurance carrier, and we are notifying you that you need to see Dr. John Euliano of Orthopedic & Sports Medicine of Erie at phone number 814-454-8287, He is the treating orthopaedic that the insurance company recognizes to relieve you of work duties.


At this present time you are on an unpaid family leave of absence, effective January 31, 2002. While on this leave you will be responsible for paying your employee benefits. On pay end February 6, 2002 your premiums will be deducted from the pay check dated February 15. However, you will be responsible for pay end February 20 and March 6, if you are still out.

Your deductions are as follows:

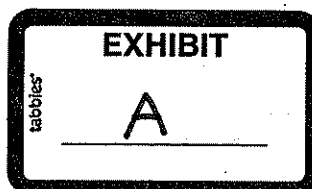
DMO Dental	\$6.43	PPO High Option	\$49.00
Employee Life Ins	\$5.36	Short Term Disability	\$12.80
Long Term Disability	\$2.31		

Your payment/check will be made out to Integrated Health Services and you will receive a receipt stating total dollar amount and what paid period you are covering.

Sincerely,


Carl Kovski
NHA

CC: Dr. Euliano
Orthopaedic & Sports Medicine of Erie





Orthopaedic and Sports Medicine of Erie

300 State Street • Suite 400A • Erie, Pennsylvania 16507
(814) 454-8287 • FAX (814) 454-8470

Nick Stefanovski, M.D.
Gary J. Cortina, M.D.
John J. Euliano, Jr., M.D.
David M. Babinski, M.D.
Kathy Sullivan, PA-C

DATE: 2-11-02

TO WHOM IT MAY CONCERN:

Hudson, Kathleen IS RELEASED TO

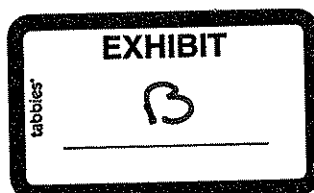
RETURN TO WORK ON 2-11-02

RETURN TO: _____ REGULAR DUTY _____ HOURS

☒ LIGHT DUTY _____ HOURS

RESTRICTIONS: 20# Lifting Restriction

John J. Euliano, Jr., M.D.



SERVICES

February 19, 2002

Certified 7000 1530 5531 5491


Ms. Kathy Hodson
2201 Keystone Drive
Erie, PA 16509

Ms. Hodson:

You will be receiving in the mail from Crawford, Slevin & Hicks. your short term disability papers. When you receive these papers there will be forms for you to fill out and for your physician to fill out. The employer will also have forms to fill out. Please return all completed forms to IHS Human Resources to be overnighted to Crawford, Slevin & Hicks. (Do not let your physician mail them; this delays the process.) Crawford, Slevin & Hicks will then review all forms to ensure everything is filled out.

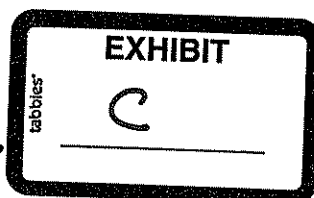
At this time the facility still has light duty work available within your 20lb. max of weight lifting. Enclosed is a copy of your light duty job description, as well as the copy you gave us of functional capacity evaluation signed and dated December 18, 2001. These light duty jobs are well within the functional capacity range. Please review these with your physician. If there is something that your physician feels you should not do please have your physician specify.

Please contact the Administrator, Carl Kovski, by February 27, 2001 to set up a time to verify your return to work date, and to go over the light duty job description.


Carl Kovski, NHA
Administrator

CC: Evan J. Jenkins, Esquire
Lisa Williams of ESIS

Enclosure



SUMMARY PAGE

Patient name : Kathleen Hodson

Eval date: 12-18-01

Referral source: Dr. M. Ang

Dx: Lumbar Disc HNP

LIFTING TOLERANCES:

Occasional

Frequent

Floor to Knuckle:

20#

10#

Knuckle to Shoulder:

10#

did not demonstrate

Carry:

17#

did not demonstrate

POSITIONAL TOLERANCES:Occasional
(0-33%)Frequent
(34-66%)Constant
(67-100%)

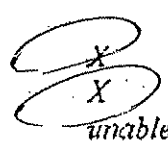
Sit:

X

Stand:

X

Walk:



unable

Squat:

Kneel:

Climb Stairs:

X

Reach Forward:

X

Reach Overhead:

X

Use Foot Pedals:

X

Grip Firmly:

X

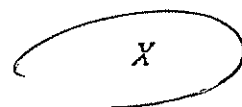
Fine Manipulation:

X

Static Head:

X

Trunk Bend:



(

):

(

):

RESULT: The client demonstrated the ability to work in the LIGHT classification category for an 8 hour day. (According to the US Department of Labor Standards.)

Signed: Evaluator: DEltmeyer, PT Date: 12-18-01

PHYSICIAN : (I concur with the above, with changes as indicated)

Physician signature here : _____ Date: _____

**• CHECK IN WITH THE SUPERVISOR UPON ARRIVAL
FOR ASSIGNMENTS**

***LIST ALL DUTIES THAT ARE COMPLETED DURING
THE SHIFT AND GIVE TO THE SUPERVISOR BEFORE
LEAVING**

-MA-51 FROM BUSINESS OFFICE

-IDDS COMPLETION

**-THIN CHARTS (GET DIRECTION FROM C. COVERDALE AND
ALL CHARTS NEED THINNED**

**-DINING ROOM - MONITOR AND FEED AT ALL MEALS DURING
YOUR SHIFT-WEEKDAYS AND WEEKENDS**

-NURSING ASSESSMENTS

**-WARD CLERK DUTIES ON WEEKENDS AND WARD CLERKS
DAYS OFF**

**-CHECK ALL DOOR NAME PLATES FOR ACCURACY AND
REPLACE**

-CHECK ALL RESIDENT NAME BANDS AND REPLACE

-SCHEDULING- CHECK WITH CAROL OTIS

-OTHER DUTIES AS ASSIGNED

-COPYING

SCHEDULED WORK HOURS WILL BE 7:00AM to 3:30PM.

RETURN TO WORK RECOMMENDATIONS

ERIE CHIROPRACTIC

Dr. Michael Ang, D.C.

2554 W. 26th St.

Erie, PA 16506

(814) 838-4444

Patient

Kathleen Hodson

Date

1, 31, 2002

Company

IHS of Erie at Bayside

Date of Injury

3, 30, 2001

Work Related

Not Work Related

I saw/treated this patient and:

☒ Patient is unable to work at this time and will be reevaluated on 2, 28, 2002

☐ Patient is able to work with no limitations or restrictions on _____

☐ Patient is able to work with the following restrictions:

PATIENT IS TO OBSERVE THE FOLLOWING LIMITATIONS:

☐ Lifting with a limit of: ☐ none ☐ 0 - 10 lbs ☐ 10 - 20 lbs ☐ 20 - 50 lbs ☐ 50 - 70 lbs ☐ 70 lbs & over

☐ Standing/Walking with a daily limit of: ☐ none ☐ 1 - 2 hours ☐ 3 - 4 hours ☐ 4 - 6 hours ☐ 6 - 8 hours

☐ Sitting with a daily limit of: ☐ none ☐ 1 - 2 hours ☐ 3 - 4 hours ☐ 4 - 6 hours ☐ 6 - 8 hours

☐ Driving with a daily limit of: ☐ none ☐ 1 - 2 hours ☐ 3 - 4 hours ☐ 4 - 6 hours ☐ 6 - 8 hours

☐ Repetitive hand motions to be avoided:

☐ Grasping ☐ Fine Manipulation ☐ Pushing and Pulling ☐ Rotation ☐ Right
☐ Grasping ☐ Fine Manipulation ☐ Pushing and Pulling ☐ Rotation ☐ Left

☐ Repetitive motions to be avoided:

☐ Bending ☐ Squatting ☐ Climbing ☐ Overhead reaching ☐ Twisting
☐ Carrying ☐ Stooping ☐ Pushing ☐ Pulling ☐ Kneeling

Other Restrictions:

Increased back pain

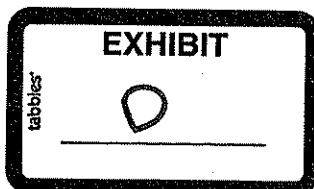
THESE RESTRICTIONS ARE IN EFFECT UNTIL 2, 28, 2002 OR UNTIL PATIENT IS REEVALUATED.

Michael K. Ang, D.C., ASDA

Doctor's Signature

Date

1, 31, 2002



THIS FORM IS TO BE FILED WITH THE EMPLOYER OR INSURER ACCORDING TO INSTRUCTIONS PROVIDED ON THIS FORM.

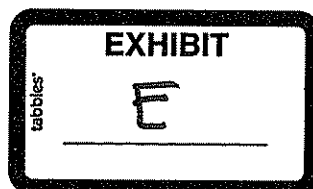
Name of Employee KATHLEEN HODSON
 Name of Employer IHS AT BAYSIDE
 Name of Insurer IHS OF ERIE AT BAYSIDE
 Claim Number (if known) C395C5257989 Date of Birth 11/26/46
 Employee SS# 200-34-7211 Date of Injury 3/30/01
 Date of Report 3/5/02
 Provider Name ORTHOPAEDIC & SPORTS MEDICINE

ORTHOPAEDIC & SPORTS MEDICINE OF ERIE, P.C.
 300 STATE ST. • SUITE 400 A • ERIE, PA 16507
 PHONE (814) 454-8287 • FAX (814) 454-8470

03/05/02	KATHLEEN HODSON	REFERRING PHYSICIAN
DATE	NAME	
<p>The patient apparently has not returned to work because of her severe pain and her family physician kept her off work for some period of time. She states that the pain is worsening. It is in her back and now it is going to her left leg as well. She has been taking muscle relaxants and Darvocet. She tells me that she just knows she is not capable of working. She did see Dr. Falasca for initial evaluation and injections are going to be carried out on March 14th. At her request, I have given her a slip that she can be off work for two weeks to facilitate the injections. I gave her a prescription for Darvocet N 100, 30 with two refills. I gave her the benefit of the doubt, however, I think that her complaints are out of proportion to the MRI findings that we have been able to ascertain up until this point in time.</p>		
<p>John J. Euliano, Jr., M.D./cao</p>		

Providers may not charge for documentation supporting a claim for payment. Providers may charge their usual fee for special reports specifically requested by the Employer/Insurer. All patient information shall be submitted with the knowledge of the patient and must be maintained as confidential by the Employer/Insurer. The insurance plan or program shall not be liable to pay for treatment until the report/claim form has been filed.

Listed on the reverse are guidelines for the completion of billing forms and submission of records.



MARY ANN ANDRIOLE-WENDEL, D.O.

ANNE-MARIE LISZKA, D.O.

308 WEST 11TH STREET

ERIE, PA 16501

814-456-8105

PA Lic No. OS-007550-L

PA Lic No. OS-006569-L

NAME

Kathleen Hudson

ADDRESS

DATE 2-18-02

R (Please Print)

Excuse from work
time now time

April 1st

- pt E medical
Condition.

REFILL _____ TIMES PRN NR

SUBSTITUTION PERMISSIBLE

M. Andriole-Wendel D.O.

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED,
THE PRESCRIBER MUST HANDWRITE BRAND NECESSARY OR
BRAND MEDICALLY NECESSARY IN THE SPACE BELOW.

04-SEP-01

TR010904_100173494-1_01_25993_0010

DEA # _____

MARY ANN ANDRIOLE-WENDEL, D.O.

ANNE-MARIE LISZKA, D.O.

308 WEST 11TH STREET

ERIE, PA 16501

814-456-8105

PA Lic No. OS-007550-L

PA Lic No. OS-006569-L

NAME

Kathleen Hudson

ADDRESS

DATE

2/14/02

R (Please Print)

excuse pt from work

2/14, 2/15, 2/16, 2/17

due to back strain

REFILL _____ TIMES PRN NR

SUBSTITUTION PERMISSIBLE

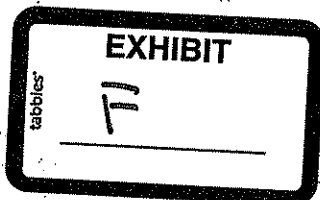
AS

D.O.

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED,
THE PRESCRIBER MUST HANDWRITE BRAND NECESSARY OR
BRAND MEDICALLY NECESSARY IN THE SPACE BELOW.

04-SEP-01

TR010904_100173494-1_01_25993_0010



BAYSIDE SCHEDULE.

MAR 5 m APR 10 Th Fr Sa Su M Tu W Th Fr Sat S M Tu W

09	30	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Hodson	7	7	-	-	7	-	7	3	-	3	3	/	/	3	/	3	3	3	/

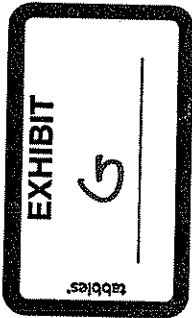
Why?

WE CAN START you in camp for a week to get back in the swing of things. Remember your 20th reservation

NO lifting have CNA's / other nurse help

Have CNA / SUPERVISORS / NURSES Push your charts 1/2 Down the hall. No Responsibility on Friday

RESIDENTS



IHS 260

20130 A MON CINDY BURGER

Business Unit: 20130

Termination Form

Name: HODSON
Last

Kathleen
First

Social Security: 200 34-7211
MI

Personal Data	Please list address employee wants final paycheck sent if different from current address.	
	Address: _____ City: _____ State: _____ Zip: _____ Phone #: (____) _____ - _____	
Job Data	Effective Date: <u>05/20/02</u> Last Day Worked: <u>05/17/02</u> Action: <u>Per Broadsett & Corp legal</u>	
	<input checked="" type="checkbox"/> Termination <input type="checkbox"/> Attendance <input type="checkbox"/> Elimination of Position <input type="checkbox"/> Mutual consent <input type="checkbox"/> Failure to return from leave <input type="checkbox"/> Death <input type="checkbox"/> License expired <input type="checkbox"/> Layoff <input type="checkbox"/> Resignation <input type="checkbox"/> Dissatisfaction <input type="checkbox"/> Gross Misconduct <input type="checkbox"/> Unsatis. Perform. <input type="checkbox"/> Transfer to Affiliate <input checked="" type="checkbox"/> Job Abandonment <u>Refused to No Have Assignment</u> <input type="checkbox"/> Retirement Is there any continuance of benefits or compensation after termination? <input type="checkbox"/> Yes If yes, please attach proper documentation <input type="checkbox"/> No	

Comments:	_____ _____ _____
-----------	-------------------------

Signatures:

Manager: _____

Date: _____

H/R: 8020 K. R.

Date: 4-24-03

Administrator: Antell

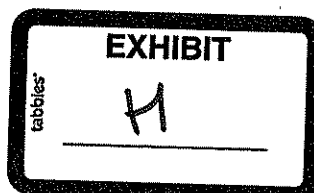
Date: 4-24-03

Budget: _____

Date: _____

Next Level Mgr: _____

Date: _____



IHS 275

Entity # 0130

Data Change Form

Cynthia 013021, A-Mon

Name: Hodson
Last

Kathleen
First

Social Security: 200 34-7211
MI

Please complete only the items which are changing.

Personal Data	Address: _____		
	City: _____	State: _____	Zip: _____
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Widowed		Citizenship: _____
	<input type="checkbox"/> Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Native <input type="checkbox"/> Alien Permanent
	<input type="checkbox"/> Separated		<input type="checkbox"/> Naturalized <input type="checkbox"/> Alien Temporary
	Effective Date: <u>05/20/02</u>		
Job Data	Action:		<input type="checkbox"/> Promotion
	<input type="checkbox"/> Data Change		<input type="checkbox"/> Transfer
	<input type="checkbox"/> FT to PT <input type="checkbox"/> PRN to PT		<input type="checkbox"/> Demotion
	<input type="checkbox"/> FT to PRN <input type="checkbox"/> PRN to FT		<input checked="" type="checkbox"/> LOA
	<input type="checkbox"/> PT to FT <input type="checkbox"/> FT to PRNT		<input type="checkbox"/> FMLA
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Personal
	New Std Hours _____ Hrs / Wk		<input type="checkbox"/> Education
	<input type="checkbox"/> Pay Rate Change		<input checked="" type="checkbox"/> Workers Compensation
	<input type="checkbox"/> Adjustment <input type="checkbox"/> Min. Wage Increase		<input type="checkbox"/> Military Service
	<input type="checkbox"/> Cost of Living <input type="checkbox"/> Union Raise		<input type="checkbox"/> Other _____
	<input type="checkbox"/> Merit <input type="checkbox"/> Across the Board		Expected Return Date: ____/____/____
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Suspension
	New Rate \$ _____		<input type="checkbox"/> Return From LOA/Suspension
	Union Code: _____		Corporate Use Only
	Effective Date of Membership ____/____/____		G/L Paytype: _____
			G/L Override: _____
			B.U. _____
	Federal Tax Data		
Tax Data	State Tax Data		
	Local Tax Data		
	Resident		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Locality: _____ County: _____		
	Withholding Allow: _____		
	Add. Withholding: _____		
	<input type="checkbox"/> \$ _____ <input type="checkbox"/> % _____		
	Resident State _____		
	<input type="checkbox"/> \$ _____ <input type="checkbox"/> % _____		
Comments: _____			

Signatures:

Manager: _____

Administrator: _____

Next Level Mgr: _____

Date: _____

HVR: _____

Date: 5-24-02

Budget: _____

Date: _____

Date: 5-22-02

Date: _____

EXHIBIT

I

IHS 274



Circulation Date: 04/30/2003

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
814-871-4632

IHS AT BAYSIDE
4114 SCHAPER AVENUE
ERIE PA 16508-0000

DECISION RENDERED COVER LETTER

Bureau Claim Number: 2296947

Insurer Claim Number: C395C525798-9/526

Petitions:

Claim-Pet

Amended To: Pet-To Seek Approval of Compromise and Release

Penalty-Pet

Amended To: Pet-To Seek Approval of Compromise and Release

Pet-To Modify Compensation

Amended To: Pet-To Seek Approval of Compromise and Release

Pet-To Suspend Compensation

Amended To: Pet-To Seek Approval of Compromise and Release

Pet-To Terminate Compensation Benefits

Amended To: Pet-To Seek Approval of Compromise and Release

KATHLEEN HODSON
2201 KEYSTONE DRIVE
ERIE, PA 16509-0000

BARRY LEVINE ESQ
LEVINE LAW OFFICE
922 PEACH ST
ERIE, PA 16501

Vs

IHS AT BAYSIDE
4114 SCHAPER AVENUE
ERIE, PA 16508-0000

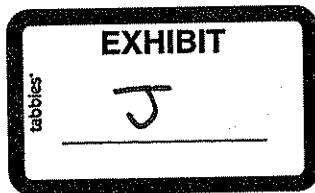
EVAN JENKINS, ESQ.
POST & SCHELL PC
STE 2800 CNG/DOMINION TWR
625 LIBERTY AVE
PITTSBURGH, PA 15222

Judge: Edward A Pastewka
3400 Lovell Place - Third Floor
13th and Holland Streets
Erie, PA 16503

The attached Decision of the Judge is final unless an appeal is taken to the Workers' Compensation Appeal Board as provided by law.

If you do not agree with this Decision, an appeal must be filed with the Workers' Compensation Appeal Board within 20 days from but not including the date of this notice.

Forms for an appeal may be obtained from the Workers' Compensation Appeal Board, Capital Associates Building
901 North Seventh Street
Third Floor South
Harrisburg, PA 17102



ESIS INC
PO BOX 15527
1 BEAVER VALLEY RD
WILMINGTON, DE 19850

COMMONWEALTH OF PENNSYLVANIA
BWC LEGAL DIV
1171 S. CAMERON STREET
ROOM 327
HARRISBURG, PA 17104-2501

CIGNA
590 NAAMANS ROAD
CLAYMONT, DE 19702-2308

Employee Witnesses & Exhibits:

Kathleen Hodson - 04/03/03

Kathleen Hodson - 04/29/03

Kathleen Hodson - 06/04/02

Kathleen Hodson - 12/02/02

Cl 01 Job Description

Cl 02 Copy of Check

Cl 03 Letter from Claimant's Counsel dated October 10, 2002

Cl 04 Accident Report

Cl 05 WC Worksheet

Cl 06 WC Denial

Cl 07 Letter from Defendant to Claimant dated February 19, 2002

Cl 08 Data Change Form

Cl 09 Stipulation

Employer Witnesses & Exhibits:

Sheila Rist - 02/13/03

David Dinges - 02/13/03

David Dinges - 04/03/03

Df 01 Work Schedule

Df 02 Assignment Sheet

Df 03 Work Schedule

Df 04 Stipulation

Judge Witnesses & Exhibits:

J 01 Notice of Workers' Compensation Denial dated July 26, 2001

J 02 Statement of Wages

Hearings:

4/29/2003 11:10:00 Held

4/11/2003 13:00:00 Held No Record

4/3/2003 09:00:00 Held

2/13/2003 13:00:00 Held

12/2/2002 13:30:00 Held

10/3/2002 11:00:00 Held No Record

9/24/2002 11:00:00 Held

6/4/2002 14:00:00 Held

4/29/2002 10:25:00 Held

Kathleen Hodson

Claim Number 2296947

Claim and Penalty Petitions and Petitions to Modify/Suspend/Terminate Compensation Benefits

Page 1 of 3

DISCUSSION

The Claimant filed a Claim Petition, alleging injuries in the course of her employment with the Defendant on March 30, 2001. Subsequently, a Notice of Compensation Payable was executed, providing for the payment of compensation to the Claimant. The Claimant also filed a Penalty Petition, alleging that the Defendant violated the provisions of the Pennsylvania Workers' Compensation Act. The Defendant filed a Petition to Modify/Suspend/Terminate Compensation, alleging that the Claimant had fully recovered as of September 26, 2001. The said Petitions were consolidated for hearing and decision. At the hearing held on said Petitions on April 29, 2003, the parties hereto submitted to me an executed Compromise and Release Agreement by Stipulation Pursuant to Section 449 of the Pennsylvania Workers' Compensation Act for my approval.

FINDINGS OF FACT

1. The Claimant filed a Claim Petition, alleging an injury in the course of her employment with the Defendant on March 30, 2001.
2. On July 10, 2002, a Notice of Compensation Payable was issued, which provided for compensation to the Claimant for total disability at the rate of \$404.90 per week based on an average weekly wage of \$607.40
3. The Claimant filed a Penalty Petition now before me, alleging that the Defendant willfully violated the Workers' Compensation Act by failing to file either a Notice of Compensation Payable or a Denial within twenty (20) days from the date of the Claimant's injury.
4. The Defendant filed a Petition for Modification/Suspension/Termination now before me, alleging that as of July 26, 2001, the Claimant had fully recovered from the said injury. It further alleged that the Claimant was offered a specific job. The said Petitions were consolidated for hearing and decision.
5. At the hearing on said Petitions held on April 29, 2003, the parties presented to me an executed Compromise and Release Agreement by Stipulation Pursuant to Section 449 of the Pennsylvania Workers' Compensation Act and requested the approval of said Agreement by me.
6. A hearing was held on said request on April 29, 2003.
7. The Claimant was represented by an attorney throughout these proceedings and negotiations leading to the execution of the Compromise and Release Agreement. The

Kathleen Hodson
Claim Number 2296947
Claim and Penalty Petitions and Petitions to Modify/Suspend/Terminate Compensation Benefits
Page 2 of 3

said attorney explained to her, in detail, the contents of the Compromise and Release Agreement.

8. The Claimant was informed of her right to a vocational evaluation. However, she waived this requirement, as did the Defendant.

9. The said Stipulation provides for the payment to the Claimant of a lump sum of \$57,500.00 in full satisfaction of all indemnity and medical benefits.

10. The said Stipulation further provides that no further medical expenses shall be paid.

11. The said Agreement further provides that the Defendant shall reimburse the Claimant for the Bill of Costs incurred by her in the total amount of \$111.95.

12. The said Stipulation further provides that the sum herein settled by the Compromise and Release Agreement, namely, \$57,500.00, represents all future wage claims for workers' compensation. The sum is compensation for impairment of the Claimant's earning power for the remainder of her life. Out of this sum, the Claimant is paying \$11,500.00 in attorney fees. The Claimant will net the sum of \$40,000.00. The Claimant's remaining life expectancy (according to the National Center for Health Statistics: Vital Statistics of the United States, 1990, Life Tables, Volume 11, Section 6. DHHS Publication No. (PHS) 92-1104, Public Health Service, Washington U.S. Government Printing Office, 1994) is 26 years or 312 months. Therefore, even though the above amount is paid in a lump sum, the Claimant's monthly workers' compensation benefit, for the purpose of determining the set-off by the Social Security Administration, shall be \$128.21 per month for 312 months, commencing April 29, 2003. The commencement date represents the last payment of temporary total disability benefits. See Sciarotta vs. Bowen, 837 F.2d. 135,140-141 (3rd Cir. 1987).

13. At the said hearing, your Workers' Compensation Judge determined that the Claimant understood the full legal significance of the Agreement.

14. Your Workers' Compensation Judge finds that the said Stipulation is explicit with regard to the payment of reasonable and necessary medical expenses.

15. Your Workers' Compensation Judge finds that the said Stipulation is in compliance with Section 449 of the Pennsylvania Workers' Compensation Act.

ORDER

The Petition for Approval of the Compromise and Release Agreement by Stipulation is hereby granted.

Kathleen Hodson
Claim Number 2296947
Claim and Penalty Petitions and Petitions to Modify/Suspend/Terminate Compensation
Benefits
Page 3 of 3

The Defendant and/or its insurance carrier is hereby ordered and directed to make payments pursuant to the said Stipulation. Upon payment of the lump sum as set forth above, the Defendant's obligation for indemnity payments to the Claimant and for the payment of medical expenses shall cease.

The Defendant and/or its insurance carrier is further ordered and directed to pay Claimant's litigation costs as above set forth.

The Claimant's Claim Petition is hereby dismissed as moot.

The Claimant's Penalty Petition is hereby dismissed as moot.


The Defendant's Termination Petition is hereby dismissed as moot.

The Defendant's Modification Petition is hereby dismissed as moot.

The Defendant's Suspension Petition is hereby dismissed as moot.

The case is closed and all papers are returned herewith.

EAP/clc
Date: 04/30/03

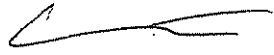


Edward A. Pastewka
Workers' Compensation Judge

COUNSEL FEES

Claimant and her counsel have agreed upon counsel fees in the amount of twenty percent (20%). Said fee is hereby approved.

EAP/clc
Date: 04/30/03



Edward A. Pastewka
Workers' Compensation Judge



Integrated

Data Valued As Of:
Version:
User ID:

INQUIRY HOME INQUIRY REPORT PROFILE OPTIONS MY GRA PORTAL LOG OUT

CLAIM ABSTRACT

CLAIM ABSTRACT | TRANSACTIONS | CLAIM NOTES | TASKS | PRINT A
PARAMETERS

CLAIM INFORMATION

File/Claim Number:	C 395 C 525798 9	Claimant:	HODSON;KATHLEEN	SSN:	
Claim Adjuster:	REP and SUP Names N/A	Event Date:	03/30/2001	Event Time:	
Data Loaded:	08/31/2005	Gender:	Female	Age:	
Coverage:	WC WORKERS COMPENSATION - ACE	Claim Type:	COMP Compensation	Status:	Clos

CLAIM DETAILS

Report Date:	04/02/2001	Activity Date:	01/13/2005	Employer Aware Date:	
Close Date:	05/13/2003	Entry Date:	04/03/2001	Hire Date:	
Re-Open Date:		Claims Made Date:		Death Date:	
Aware to Report Days:	3 Days	Event to Close:	774 Days	Report to Close:	
Claims Made to Close:	N/A	Event to Report:	3 Days	Event to Aware:	
				Hire to Event:	

Description: LIFTING PATIENT FROM WHEELCHAIR HERNIATED DISC L4-5
WC Denial Indicator: N **WC Denial Reason:**
Litigated Claim Indicator:

Catastrophe Number:
Cause: H1 Overexertion - In Lifting Objects
Hazard: M5 Taking Unsafe Position or Posture - Improper Lifting
Damage/Injury: 19 Ruptured Disc

Special Analysis: #####960#### (Positions 42-66)
Plant Division: LTC0130####

Location: 0706 ERIE @ BAYSIDE 4114 SCHAPER AVE, ERIE PA **Location Of Event:** ERIE,PA
Site: LTC0130 **Event Zip:** 16508

Event State: PENNSYLVANIA **Jurisdiction:** PENNSYLVANIA

Carrier: 100 ACE AMERICAN INSURANCE
Policy/Contract: C4WLR309074 **Policy Period:** 01/01/2001 **Thru:** 01
Occupation: NURSING HOME - LONG TE **Job Class:** 960 Convalescent or Nursing Home - all employees (E:1-58) **Weekly Wage:** 60

CONTACT INFORMATION

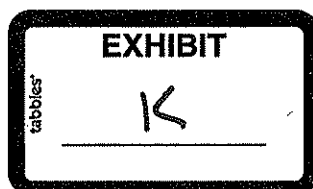
Claim Proc. Office:	395	Brandywine		
Supervisor:		Not Listed	Office Phone:	Not Listed
Representative:		Not Listed	Office Phone:	Not Listed

For US Claim Office information, including address and fax number, see the Claim Directory @ www.esis.com. For ACE International Claim Office Information, including address, fax and phone numbers click on the [ACE International Claims Directory](#).

ESTIMATED LOST TIME INFORMATION

Disability Duration

Disability	Disability Start Date	Disability End Date	Estimated Lost Time
------------	-----------------------	---------------------	---------------------



Disability Profile

Social Security Number: 200-34-7211
 Total Disability Paid To Date: 19,840.10
 Total Lost Time To Date: 344 days

FIELD CASE MANAGEMENT

Case Summary as of: 08/14/2005 [Expand](#)

Duration	134	Invoice Amount	1,319.40	Indemnity Savings	0.00	Medical Savings	0.00
----------	-----	----------------	----------	-------------------	------	-----------------	------

Case Referrals

Open Date	Close Date	Duration
01/22/2003	06/05/2003	134

Data on this screen reflects input of other than ESIS, Inc. adjusters. Due in part to the dynamic nature of the data, ESIS, Inc. makes no warranties or representations respecting the accuracy, completeness, or reliability of such data for any purpose.
 Savings estimates are not indicative of the overall impact of the FCM program. A more accurate measure is the Total Loss Cost reduction attributed to all the claims in the FCM program.

LEGAL DISPUTE INFORMATION

Subletter: A

Type Of Counsel:

Dispute Received Date: 6/3/2002
 Disposition Date: 4/29/2003
 Docket Number:

First Notice of Suit: N
 Dispute Type Code: RO REPRESENTATION ONLY

Plaintiff Firm IRS Number:
 Plaintiff Attorney Name:
 Plaintiff Firm Name:

Defendant Firm IRS Number:
 Defendant Attorney Name:
 Defendant Firm Name:

Outside Referral Reason:

Legal Dispute Information included above is dynamic and may be only partially completed as the facts dev

FINANCIAL INFORMATION

Claim Detail Totals - USD US Dollars

Trans	Type	Status	Paid Indemnity	Paid Medical	Paid Expense	Outstanding Reserves	Recovery Incurred	Net Recove
1	COMP	Closed	77,452.05	26,814.21	15,091.35	0.00	0.00	119,357

Claim Totals - USD US Dollars

	Gross Reserve	Paid	Outstanding Reserves	Incurred	Recovery	Incurred Net Recove
Indemnity	0.00	77,452.05	0.00	77,452.05		

Total

0.00

119,357.61

0.00

119,357.61

0.00

119,357.

CLAIM ABSTRACT TRANSACTIONS CLAIM NOTES TASKS PRINT ABSTRACT PARAMETERS



Copyright © 2001 ESIS All Rights Reserved

112039

RESIGNATION LETTER

I, Kathleen Hodson, hereby resign my employment with Integrated Health Services, Inc., effective April 29, 2003. I understand and agree that my resignation is permanent and irrevocable. In so resigning, I hereby waive any right to reapply for employment with this employer.

This resignation does not operate as a waiver and/or final release of any non-workers' compensation claims I have pending against Integrated Health Services, Inc., including my pending claim before the Pennsylvania Human Relations Commission/EEOC.

This letter does not waive my right to any vacation pay, personal/sick pay that I am entitled to.

DATE:

4/29/07

Kathleen Hodson
Kathleen Hodson

Barry Levine, Esquire
Barry Levine, Esquire

EXHIBIT

tabbles

L